Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Agency Mission, Vision, and Values

Mission Statement:

The Department of Mental Health, Mental Retardation, and Substance Abuse Services (the Department) provides leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by mental illness, mental retardation, or substance use disorders (alcohol or other drug dependence or abuse). The Department seeks to promote dignity, choice, recovery, and the highest possible level of participation in work, relationships, and all aspects of community life for these individuals.

Agency Vision:

We envision a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life, including work, school, family and other meaningful relationships.

Agency Values:

- **Focus First on Individuals Receiving Services**
  - Our decisions and actions consider first the best interests of individuals who receive services and their families.
  - We respect the potential and capacity of each individual receiving services.
  - We value and support the healing and recovery process.
- **Responsiveness to External and Internal Customers**
  - We seek input and involvement from our customers.
  - We share ideas and remain open to different opinions.
  - We listen to and respect what our customers say and respond promptly to their requests.
- **Partnership and Collaboration**
  - We create opportunities for partnerships, encourage teamwork, and support each other to succeed.
  - We accept shared ownership and seek win-win (mutually acceptable) solutions.
  - We communicate openly and clearly.
  - We are willing to take risks as we look for creative solutions and new ways of solving problems.
  - We make decisions and resolve problems at the level closest to the issue.
- **Professionalism, Integrity, and Trust**
  - We recognize and celebrate individual and team successes.
  - We use valid data that reflect best practices and positive results and outcomes.
  - We take responsibility for ourselves, for our actions, and for how these actions affect others.
  - We develop a supportive and learning environment and work continuously to improve the quality of the services we provide.
  - We keep our word and deliver what we promise.
  - We incorporate our values into everyday decisions.
- **Stewardship**
  - We protect the assets and interests of the entire services system.
  - We value and take care of staff.
  - We use the Commonwealth's resources in the most effective and efficient manner.

Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Agency Executive Progress Report

Current Service Performance

Virginia's publicly supported mental health (MH), mental retardation (MR), and substance abuse (SA) services system is comprised of the Department's central office and state hospitals and training centers; a network of 40 community services boards, behavioral health authorities, or local government departments with policy-advisory boards (hereafter referred to as CSBs); local governments that establish, fund, and provide various administrative supports to CSBs; private and public providers of services licensed by the Department; and providers of other supports such as housing, job training, social services, and income assistance.

Through a two year Integrated Strategic Planning process, the Department, in partnership with services system stakeholders, has worked to develop a blueprint with specific action steps for transforming the Commonwealth's public MH, MR, and SA services system. This process has involved hundreds of interested citizens who have examined emerging trends and model programs; assessed services system strengths, opportunities, challenges, and critical issues; explored opportunities for restructuring the current system; and developed recommendations for state and local actions to change the current services system's "crisis-response" orientation to one that provides incentives and rewards for implementing the vision of a consumer-driven system of care.

The Department also has worked to assure that public and private providers of MH, MR, and SA services in over 2,700 services locations adhere to licensing standards and protect the safety and human rights of consumers receiving their services. With a staff-to-licensed service ratio of 1:192, (compared to 1:17 for assisted living facilities and 1:7 for nursing homes), the Department met its Executive Performance Agreement goal to reduce, by 64 percent, provider violations of licensing regulations by improving monitoring and oversight. Since July 2004, 300 new MR group home beds and other new MR Home and Community-Based Waiver services were licensed. Ten Programs of Assertive Community Treatment (PACT) and Intensive Community Treatment (ICT) teams also were licensed under the new regulations.

The Department directly operates nine state hospitals, five training centers, one medical center, and one residential treatment program for individuals who meet commitment criteria as sexually violent predators. These 16 state facilities provide highly structured intensive inpatient treatment, rehabilitation, and habilitation services.

• The nine state hospitals provide inpatient psychiatric acute stabilization, intermediate, and rehabilitation services to children, adults, and geriatric individuals. On June 30, 2005, the operating capacity of the state hospitals was 1,686 beds. The total number of patients on facility books was 1,513, for an overall occupancy of 90 percent.

• The five mental retardation training centers provide residential care and training in areas such as language, self-care, independent living, academic skills, and motor development. On June 30, 2005, the operating capacity of the training centers was 1,629 beds. The total number of residents on facility books was 1,517, for an overall occupancy of 93 percent.

• The one medical center provides medical and skilled nursing services to state facility patients and residents who have severe physical and medical needs. On June 30, 2005, the operating capacity of this center was 74 beds. The center served 67 patients (91 percent occupancy).

• The Department's newest facility, a residential treatment program for sexually violent predators, opened in FY 2004. On June 30, 2005, the operating capacity of this facility was 36 beds. The facility served 16 residents (44 percent occupancy).

In FY 2005, state hospitals served 5,723 patients, training centers served 1,646 residents, and Hiram Davis Medical Center served 173 patients. An unduplicated count of individuals served across all of these state facilities totaled 7,427.

State facilities achieved a 46 percent reduction in the utilization of seclusion and restraint between April 2004 and April 2005. While month-to-month data varies, there is evidence of a steady decline in the use of restrictive procedures in state facilities. Approximately 10,000 state facility staff, including more than 100 trainers, have been trained in Therapeutic Options for Virginia (TOVA), a new behavior interaction program developed to improve staff and consumer interactions, thereby reducing the need for restrictive interventions.

The Department supports the provision of accessible and effective public MH, MR, and SA treatment and prevention services through a network of CSBs that are established by local governments. CSBs are the single point of responsibility and authority for assessing individual needs, accessing a comprehensive array of services and supports, and managing state-controlled funds for community-based services. CSBs deliver community-based emergency, local inpatient, outpatient, case management, day support, residential, and prevention and early intervention services, either directly or through contracts with private providers. CSBs also prepare discharge plans for state facility patients and residents who are returning to the community. The Department's relationships with the CSBs are based on the community services performance contract.

• In FY 2005, CSBs served 195,132 individuals, of whom 115,173 received MH services, 26,050 received MR services, and 53,909 received SA services.

• For FY 2005, a totally unduplicated count of consumers of CSB services across all program areas (MH, MR, and SA services) indicated 174,183 individuals received services through CSBs.

In FY 2005, CSBs provided the following services to consumers. These consumers may have received more than one type of service and services in more than one program area.

- Emergency services to 51,433 consumers,
- Local inpatient services to 4,841 consumers,
- Outpatient and case management services to 194,231 consumers,
- Day support services to 16,393 consumers,
- Residential services to 24,447 consumers, and
- Early intervention services to 12,499 consumers.

Community MH, MR, and SA services, already strained to keep pace with demand and with hundreds of people on waiting lists for services, could potentially receive service requests from thousands of additional individuals, based on statistical prevalence methodology.

• The 2006-2012 Comprehensive State Plan, based on statistical prevalence methodologies, estimates that 392,138 adults in Virginia have a serious mental illness, 73,877 children or adolescents have a serious emotional disturbance with significant impairment, 67,477 individuals have mental retardation, 18,116 young children

(from 0 to 5 years of age) have developmental delays requiring early intervention services, and 335,545 adults or adolescents have an illicit drug or alcohol dependence disorder. While not all of these 887,153 individuals will seek services from the public sector, many of them will do so.

• Further, data collected for the 2006-2012 Comprehensive State Plan identifies over 6,000 adults and children on waiting lists for MH services, over 5,000 individuals on waiting lists for MR services, and over 3,400 adults and children or adolescents on waiting lists for SA services. Virginia's ongoing population growth will result in the need for additional services in each of the three program areas.

There are additional disability-specific, community-based service needs that are significant and compelling.

• Nearly 75 percent of all youth in detention centers have at least on diagnosable mental disorder, yet only five CSBs receive funding to provide joint services with juvenile detention centers. Additional consumers of MH services and family members will need services from consumer-run initiatives and consumer and family member education and training programs. This is essential to achieving the Department's vision of a service system that empowers, supports, and promotes the dignity and self-determination of consumers.

• While the number of Medicaid MR Waiver recipients has increased by 860 in the last two years, the waiting list for community-based MR services and supports is anticipated to grow by approximately 500 new individuals. Approximately 2,000 students graduate annually from special education classes and need community MR services. CSBs serve a large number of infants and toddlers in programs funded through the Part C program; the number of infants and toddlers in need of these services is expected to grow over the biennium as a result of population growth, better outreach and case finding efforts, and enhanced Part C child find activities.

• The 2003 National Survey on Drug Use and Health estimates that there are 98,000 Virginians needing, but not receiving SA services. Patterns of drug use reflect an increased prevalence of prescription drug and methamphetamine abuse and dependence. These important changes in the Department's customer base must be addressed by providing accessible, responsive, and individualized community-based services and supports.

In April 2005, CSBs estimated the number of weeks that individuals waited for their services. CSBs reported that, on average, individuals waited three to four weeks for an initial assessment performed by CSBs.

• For CSB MH services, adults, on average, waited longest for highly intensive residential services (126 weeks), intensive residential services (58 weeks), and supervised residential services (43 weeks). Children and adolescents waited longest for highly intensive residential services (12 weeks) and alternative day support arrangements (12 weeks).

• For CSB MR services, adults, on average, waited longest for intensive residential services (115 weeks), highly intensive residential (82 weeks), supervised and supportive residential services (75 weeks), rehabilitation (68 weeks), sheltered employment (48 weeks), behavior management services (47 weeks), alternative day support arrangements (42 weeks), and supported employment group model services (38 weeks). Children and adolescents waited longest for supervised residential services (237 weeks), highly intensive and intensive residential services (202 weeks), rehabilitation (83 weeks), and supportive residential services (53 weeks). For MR Waiver services, on average, adults waited longest for personal response services (87 weeks), nursing services (74 weeks), and therapeutic consultation (48 weeks). Children and adolescents waited longest for

personal assistance services (78 weeks), nursing services (56 weeks), and therapeutic consultation (40 weeks).

• For CSB SA services, adults, on average, waited longest for methadone detox (11 weeks), intensive outpatient (8 weeks), opioid replacement services (7 weeks), psychiatric services (7 weeks), transitional or supported employment (7 weeks), sheltered employment (7 weeks), medication services (6 weeks), and supported employment (6 weeks). Adolescents waited longest for medication services (6 weeks), psychiatric services (5 weeks), and counseling (4 weeks).

Each year, the Department measures consumer perceptions of services provided by CSBs. The most recent survey, which is based on the federal Mental Health Statistics Improvement Program's (MHSIP) Consumer-Oriented Mental Health Report Card, was conducted in October 2004. The majority of adult consumers participating in the survey (N = 7,363) reported positive perceptions of CSB services. In general, consumers who had been receiving services for longer periods reported more positive perceptions than consumers who received services for only a short time. These differences were significant for all areas.

• For access, the percentage of consumers who reported good access to services, about 83 percent of consumers reported satisfaction.
• For appropriateness, the percentage of consumers reporting that they received services appropriate to their needs, 86 percent reported satisfaction.
• For outcome, the percentage of consumers who reported positive change as a result of the services they received through the CSB, 73 percent reported satisfaction.
• For satisfaction with services, the percentage of consumers who reported general satisfaction with CSB services, 87 percent reported satisfaction.

Although this survey has been administered annually for the past nine years, the current instrument and methodology has been used since 1999. Between 1999 and 2004, consumer perceptions of services have remained positive. These percents have been fairly consistent over time, with general satisfaction, appropriateness, and access receiving the highest ratings and outcomes receiving the lowest.

The Department administers a similar annual survey, the Youth Services Survey for Families, to track caregiver perceptions of MH services provided by CSBs to their children. The majority of the caregivers participating in the survey (N = 1,475) reported positive perceptions of CSB services. Caregivers who were still receiving services for their children were significantly more likely to report positive perceptions of the services than were caregivers of youth who were not currently receiving services. Caregivers also were significantly more likely to report positive perceptions of services if their children had remained at home for the last six months as opposed to some type of out of home placement.

• For access, the percentage of caregivers who reported good access to CSB services, 79 percent of caregivers reported a positive perception.
• For cultural sensitivity, the percentage of caregivers who perceived CSB service providers to be respectful and sensitive to their differences, over 88 percent reported positive perception.
• For family participation in treatment, the percentage of caregivers who reported participation in their children's treatment, 88 percent reports a positive perception.
• For satisfaction with services, the percentage of caregivers who reported general satisfaction with CSB services, about 72 percent reported a positive perception.
• For outcome, the percentage of caregivers who reported positive change in their children as a result of the services they received through the CSB, 53 percent reported positive perception.

Comparison of results of the 2004 survey with those of previous surveys administered in 2000, 2001, and 2003 indicates that caregiver's perceptions of services for their children have remained stable over time with respect to access, participation in treatment planning, cultural sensitivity, and satisfaction. For outcomes, caregiver perceptions of the effectiveness of services have significantly improved. In the 2004 survey, 53 percent of caregivers perceive that their children have improved as a result of services compared to only 48 percent in the 2000 survey.

The Synar Amendment to the federal Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act requires that states conduct annual inspections of randomly selected tobacco retail outlets to determine how likely it is that underage youth are able to purchase tobacco products. The states must conduct compliance inspections of tobacco vendors as a condition for receipt of Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, which support community SA treatment and prevention services and total approximately $42 million. The rate of noncompliance must not exceed a previously agreed upon target rate, or 20 percent noncompliance by FFY 2003. The current rate of 13 percent is well below the 20 percent target.

Productivity

The Department has implemented the following improvements to increase productivity, improve services delivery, and achieve savings.

• Regional Management of Inpatient Beds: Since 2002, the Department has supported a regional approach to service planning, utilization, and delivery. Through a joint "ownership" and monitoring of bed use, CSBs and state and local hospitals have established regional utilization review and management processes. These regional processes have increased communication and collaborative problem-solving efforts by key stakeholders, resulting in more effective and efficient utilization of local hospital and state inpatient psychiatric beds. Because lengths of stays are monitored closely and continuity of care has improved, more people are being served and outcomes are comparable or better.

• CCS Implementation: Until FY 2004, the Department collected and utilized only aggregate, summary data about consumers receiving services from CSBs, except for some individual data about consumers receiving SA services. As state and federal reporting requirements became more extensive and complex, the Department and CSBs worked together to develop a way to respond to these requirements in a less burdensome manner. The community consumer submission (CCS), implemented in FY 2004, extracts data from local CSB information systems. A second version, CCS 2, is being implemented to address data and reporting requirements that emerged after development of the original CCS. The successful implementation of CCS has allowed CSBs and the Department to comply with reporting requirements more efficiently and effectively, eliminate repetitive data entry in different automated or manual reports, respond more easily to ad hoc data requests, maintain fewer stand-alone software applications and reports, and reduce their respective administrative workloads.

• MEDIS Project: This pharmacy data warehouse includes information about psychiatric medication utilization of individuals receiving services in state facilities and in the community through the Aftercare Pharmacy. This system allows the Department to evaluate prescribing practices and take necessary measures to assure best practices are followed.

• Agreement with Anthem: The Department established, effective January 1, 2005, an agreement with Anthem Blue Cross and Blue Shield that will allow the state facilities to use Anthem's negotiated discount prices for inpatient and outpatient medical and dental services provided to state facility patients and residents. This should result in estimated savings of 25 percent for these services.

• Facility Direct and Indirect Costs Study (Phase I): This study is inventorying cost information and analyzing and establishing a common methodology for consistently capturing facility cost data under direct and indirect areas. The Department is establishing a new "direct support costs" category to provide greater clarity about facility operations. The results of this analysis will be incorporated into a management information system. Two additional phases are planned: a staffing analysis and a capital projects analysis.

• Electronic Medical Records: The Department is implementing an electronic medical record system that includes three phases: HIPPA Billing System (phase I), Medication Management System (phase II), and Electronic Treatment Plan (phase III). Phase I of this project has been completed.

• Aftercare Pharmacy Formulary and Pocket Guide to Psychopharmacology: This pocket guide was developed and disseminated to state facilities, CSBs, and others to better coordinate care among providers.

• Financial Management System (FMS) Migration: The current HP3000 hardware and operating system for FMS will be discontinued at the end of calendar year 2005 because the vendor will no longer provide technical support. The Department will enhance productivity by installing a replacement Windows operating system and MS-SQL on three regional sites, reducing two sites from the current IT environment.

• Central Office Re-engineering: The central office Finance and Administration Division has eliminated two office director positions. This re-engineering will generate some savings, empower staff to make decisions, and encourage efficiencies resulting from cross training and elimination of paperwork.

Major Initiatives and Related Progress

• Reinvestment and Restructuring: The services system is engaged in a major transformation initiative to replace its historic emphasis on institutionally based care to one that promotes opportunities for individuals with mental illnesses, mental retardation, or substance use disorders to fully participate in meaningful work and community life. Partnerships among key services system players at all levels have transformed thinking about how services and supports should be funded, organized, and delivered. Some services that were once available only in state facilities are now provided in local hospitals or other community programs. In FY 2003, three regional Reinvestment projects were implemented. These projects used targeted resources at three state hospitals to expand community services. Each project was developed by and tailored to the needs of its own region. All three projects promoted regional collaboration among public and private providers to reduce reliance on state hospitals for services that could be provided more appropriately and effectively in the community. The projects purchased acute psychiatric beds from community hospitals, established new community-based crisis stabilization services, expanded community services capacity, and provided individualized discharge assistance for long-term hospital patients. With the community capacity developed through these projects, 25 beds were closed at Western State Hospital in Staunton, 40 beds were closed at Central State Hospital in Dinwiddie, and 43 beds were closed at Eastern State Hospital in Williamsburg.

• Expansion of Community Capacity: The Department has invested in services that enable many individuals with acute or complex needs to remain close to their homes and natural supports. These include Programs of Assertive Community Treatment (PACT) teams, crisis stabilization services, local inpatient acute psychiatric services, individualized discharge assistance, and MH services for children and adolescent who are not in the Comprehensive Services Act mandated populations. These new services and significant increases in the MR Home and Community-Based Waiver program have expanded options that were not previously available to consumers and families.

• Co-Occurring Services Integration Grant (COSIG): In October 2004, the Department was awarded a $3.5M COSIG grant to enhance the infrastructure of Virginia's public SA and MH services system to support the integration of services to individuals with co-occurring mental illness and substance use disorders. The COSIG grant will enhance the current data infrastructure that guides decisions concerning service delivery for persons with co-occurring disorders.

• Juvenile Justice/Mental Health Initiative: Through this Department initiative, 1,000 children in five detention centers have accessed needed MH services provided by CSBs. Access to these services reduced detention center placements to the Commonwealth Center for Children and Adolescents and reduced the detention center recidivism rate for these individuals.

• Consumer and Family Networks: In 2004, a MH consumer organization (VOCAL) received a state infrastructure grant to develop a statewide consumer network. The Department provided additional support to sustain this initiative, which has provided outreach to 418 consumers and 235 others since November 2004. The Department also contracted with a state advocacy organization, PACCT, to pull together family groups and parent resource centers into an integrated family coalition for the Commonwealth, using the Federation of Families model.

• Leadership Training: In May 2005, 38 senior managers from the Department's central office and state facilities attended intensive leadership training at the Weldon Cooper Center for Public Service at the

University of Virginia. This training focused on leadership styles and team building. It provided an initial foundation for Department efforts to become a high performance organization.

Virginia Ranking and Trends

State Profile Information collected by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute found that in FY 2002, Virginia ranked 33rd among the states in per capita expenditures for mental health services. Virginia ranked 9th among the states in per capita expenditures for state inpatient mental health services and 39th in per capita expenditures for community-based mental health services. Virginia's per capita expenditure for community mental health services ($25.18) was less than half the national per capita expenditure ($58.80). Virginia's per capita expenditure for state inpatient mental health services ($38.64) was considerably more than the national per capita expenditure ($26.63). Nationally, state mental health agency-controlled expenses in FY 2002 were 1.95 percent of total state government expenditures, compared to 1.8 percent in Virginia.

According to the University of Colorado, in its analysis of state developmental disabilities programs, Virginia increased its spending for community developmental disabilities services by 30 percent between FY 2000 and FY 2002 and again by 9 percent between FY 2002 and 2004. However, Virginia's state fiscal effort in FY 2004 – it's spending for MR/DD services per $1,000 of aggregate statewide personal income – ranked 45th for all MR/DD services, 47th for community services, and 38th for institutional services. In FY 2004, Virginia ranked 41st in its federal and state MR Home and Community-based Waiver spending per citizen of the general population, or $33 compared to a national average of $54.

According to the National Center on Addiction and Substance Abuse at Columbia University (CASA) , Virginia ranks 33rd ($62.25 per capita) in the burden of substance abuse on state programs for each dollar spent on prevention, research and treatment, 31st in the percent of the state budget (0.184 percent) spent on substance abuse treatment, research and prevention, and 33rd of 47 states surveyed in per capita spending on prevention, treatment and research.

According to the National Survey on Drug Use and Health, 2002:

- Virginia ranks 30th out of the 50 states and the District of Columbia in the prevalence of any illicit drug use in the past month by individual ages 12 or older, based on the 2002 and 2003 National Surveys on Drug Use and Health. Virginia's rate of 7.68 percent (453,000 individuals) is below the national rate of 8.25 percent.

- Virginia ranks 47th out of the 50 states and the District of Columbia in the prevalence of binge use of alcohol in the past month by individual aged 12 or older, based on the 2002 and 2003 National Surveys on Drug Use and Health. Virginia's rate of 20.51 percent (1,211,000 individuals) is below the national rate of 22.75 percent.

- Virginia's rank is 34th regarding dependence on or abuse of any illicit drug or alcohol in the past year – 9.09 percent (537,000 individuals 12 or over) compared to a national average of 9.22 percent.

When compared to the latest national survey results available (National Association of State Mental Health Program Directors NASMHPD Research Institute, 2003), Virginia's adult consumers of CSB MH services are at least as satisfied or more satisfied, except in the area of Access, than their peers across the country. The following percentages of respondents reported satisfaction.

- General Satisfaction: Virginia: 87 percent Nationally: 87 percent
- Access: Virginia: 83 percent Nationally: 85 percent
- Outcome: Virginia: 73 percent Nationally: 72 percent

Virginia caregivers of children and adolescents receiving CSB MH services report significantly more positive perceptions of family participation in treatment planning and cultural sensitivity than the national average. Perceptions of access are comparable; however, in the areas of satisfaction and outcomes, Virginia caregivers are significantly less positive than the national average. The following percentages of respondents reported a positive perception.

- General Satisfaction: Virginia: 72 percent Nationally: 78 percent
- Access: Virginia: 79 percent Nationally: 81 percent
- Family Involvement: Virginia: 88 percent Nationally: 80 percent
- Cultural Sensitivity: Virginia: 88 percent Nationally: 78 percent
- Outcome: Virginia: 53 percent Nationally: 60 percent.

Customer Trends and Coverage

The local public MH, MR, and SA services system has continued to increase in complexity during the past decade. CSBs are now serving more consumers with more severe disabilities. For example, the numbers of consumers with serious mental illnesses or serious emotional disturbances increased by 25.82 percent between FY 1997 and FY 2003. Services provided to consumers have increased in intensity or specialization. For example, the average units of service per consumer for mental health case management increased from 16.87 hours per consumer in FY 1997 to 19.03 hours in FY 2003, a 12.80 percent increase in intensity.

The demand for various community services is relatively uncontrolled and fluctuates over time by locality in response to a wide variety of influences. These influences include the availability or non-availability of services from CSBs or other agencies, shifting demographic patterns (e.g., variable population growth and migration among regions) across Virginia, and decisions made by consumers or family members about when, where, and from whom to seek services.

Between FY 1976 and FY 1996, the average daily census at the state mental health facilities, excluding the Hiram Davis Medical Center, declined by 3,745, or 63 percent (from 5,967 to 2,222). Between FY 1996 and FY 2005, the average daily census declined by 33 percent (from 2,222 to 1,478). Between FY 1996 and FY 2005, excluding the Hiram Davis Medical Center and the Virginia Center for Behavioral Rehabilitation, admissions declined by 30 percent (from 7,468 to 5,232). Separations also declined by 30 percent (from 7,529 to 5,236).

Between FY 1976 and FY 1996, the average daily census at state training centers declined by 2,161, or 51 percent (from 4,293 to 2,132). Between FY 1996 and FY 2005, the average daily census declined by 29 percent (from 2,132 to 1,524). Between FY 1996 and FY 2005, training center admissions increased by 31 percent (from 87 to 114). Between FY 1996 and FY 2005, training center separations decreased by 22 percent (from 223 to 174).

Future Direction, Expectations, and Priorities

• Changes in the population needing MH, MR, and SA services over the next six years are likely to mirror those in the overall United States population. Community MH, MR, and SA programs will increasingly serve an older population, many of whom may experience complications from a variety of physical illnesses. An increasing number of individuals will require CSB services and supports to enable them to reside in a nursing home or assisted living facility. Changes in the state's Medicaid benefit package also will be needed to better address the needs of medically fragile individuals who also have a mental illness, mental retardation, or substance use disorder. To avoid over reliance on state inpatient care for these individuals, it will be important to create more flexible Medicaid reimbursement mechanisms for community-based services that are appropriate for older individuals with mental illness.

• Significant numbers of individuals receiving public MH, MR, and SA services are either low income or indigent. Many also have disabilities that make them dually eligible for Medicare and Medicaid coverage. These individuals will be fully or partially eligible for new Medicare Part D pharmacy program coverage. Approximately 61 percent of individuals receiving services in state facilities will meet Medicare Part D eligibility requirements. According to the Centers for Medicare and Medicaid Services (CMS), Medicare Part D will maintain broadly-structured formularies, with all or substantially all of the following six major drug categories included in the program's formularies: antidepressants, antipsychotics, anticonvulsants, anticancer agents, immunosuppressants, and HIV/AIDs medications. This means that state facility patients and residents should continue to have access to needed medications. The new Part D program requirements will affect state facility pharmacy operations. The Department must assure that the pharmacy information systems used by state facilities are compatible with any new Medicare processing requirements. State facility pharmacists will be required to update their facility's pharmacy database to reflect the new formularies and to provide individual patient or resident Medicare eligibility and specific plan data. State facility pharmacy system software enhancements will be required for Medicare Part D billing. Once CMS has approved specific plans that will be available in Virginia to process payments for medications, the Department will contract with each operating plan. These contracts must be in place by December 31, 2005. Billing for Part D medications will be accomplished directly from state facility pharmacy systems electronically. The Department projects approximately $12 million annually in Medicare Part D collections, beginning January 1, 2006.

• Medicare Part D also will affect community programs on January 1, 2006. Of the 17,000 individuals receiving Aftercare Pharmacy services, an estimated 53 percent should be eligible for Medicare Part D pharmacy services. About 6,000 are projected to be dually eligible for Medicare and Medicaid services. They will not have to pay premiums, deductibles, or co-payments, and there should be no coverage gap. About 3,000 individuals are not projected to be dually eligible. They will have Medicare Part D coverage but will be responsible for some costs. All individuals who are eligible for Medicare Part D will be diverted from the Aftercare Pharmacy to local pharmacies. The Aftercare Pharmacy will implement procedures to determine each individual's Part D eligibility prior to filling prescriptions.

• The Department has developed a Mental Retardation Services and Supports by Level of Care Model to expand the range of services and supports options to individuals who meet the level of care criteria established by Medicaid for ICF/MR eligibility. The MR model promotes flexibility, choice, and independence. It includes five levels of services and supports that range from basic community-based non-residential services and family supports to intensive 24-hour center-based services. Continued investment in community services and supports capacity is a necessary prerequisite for implementation of the MR model. This includes expansion of

community MR Waiver slots to prevent increased demand for the most intensive center-based services, increases in MR Waiver rates to assure community capacity, and expansion of community services and supports, including non-MR Waiver services family supports. The MR model also would develop community living options such as small community ICF/MR and MR Waiver group home capacity as alternatives to more intensive services. The MR model would establish smaller center-based facilities, or intensive support centers, to provide residential care to those individuals who are not able to be served in small ICF or MR Waiver homes. These center-based facilities also would provide medical, dental, behavioral, and other services and supports for community residents through Regional Community Support Centers.

• With advances in medical and assistive technologies, individuals with severe or profound levels of mental retardation now live a nearly normal lifespan. As these individuals grow older, they are likely to develop other health problems such as Alzheimer's disease that will require specialized services and supports. Services must be designed to address the evolving needs of these individuals over time to provide continuity in their care and living environments. The Department and the services system must look at new models of community-based services as alternatives to training center placement for these individuals.

• As Virginia's population ages, there will be increasing demand for specialized substance abuse services for older persons with substance use disorders. If abuse of alcohol and legal drugs among older Virginians were to continue at the same rate as their U.S. counterparts (17 percent), demand for specialized treatment services could be 1.5 times greater in 2030 because of population growth.

• The current generation of parents of individuals with mental retardation are aging and many, due to infirmity or death, will soon be unable to care for their adult children with mental retardation. According to a national study of state services, the majority of these individuals reside with family members. The number of persons with MR living with caregivers aged 60 years and older in 2002 was estimated to be 16,903. Demand for alternative housing and structured support options will increase dramatically as the large cohort of baby boomer parents reach retirement age.

• The service system's increasing ability to assess mental retardation and co-occurring mental or physical disabilities, including mental illness, autism, and severe physical disabilities, will challenge a system that is already deficient in addressing support and treatment needs of these groups. Greater numbers of children currently coming through Virginia's school systems are being identified as having autism, both with and without a co-occurring condition of mental retardation. This increase reflects a national trend that some label an epidemic. A significant proportion of individuals seeking treatment for substance use disorders also suffer from some form of mental illness. Left undiagnosed and untreated, mental illness will certainly cripple the individual's effort to attain stability and remain drug or alcohol free. Yet, too few professionals are trained to address both disorders, and there is a dearth of psychiatric resources available to treatment programs for substance use disorders.

• A review of 2002 National Household Survey on Drug Use and Health data suggests that the use of illicit substances (e.g., cocaine and heroin) and the non-medical use of prescription pain relievers and stimulants, particularly among youths and young adults, are increasing. Alcohol use has been increasing steadily since 1990, with youth under age 18 accounting for much of the increase. Adolescent use nearly doubled, from 2.2 million in 1990 to 4.1 million in 2000, with gender distribution about equal.

• The southwestern portion of the state continues to experience a significant increase in overdose deaths from

methadone (a synthetic opiate) prescribed by rural physicians as an analgesic and lacks any significant capacity to effectively treat opiate addiction. Methamphetamine use is also becoming more prevalent, spreading from the western portion of the United States.

• Significant advances continue to occur in treatment technologies. Evidence-based, promising, and emerging treatment models requiring training and ongoing supervision to assure fidelity are rapidly becoming available to be disseminated to community practitioners. Appropriate integration of these models and advancement into the public services system requires access to treatment professionals who are trained (or willing to be trained) to provide these services, as well as administrators who understand their applications.

Impediments

• Communities lack basic MH, MR, and SA services capacity to address existing demand and anticipated population growth. As state general funds have remained static and costs have increased, treatment capacity is declining, particularly for individuals who are not eligible for Medicaid. This has further limited the service system's ability to meet demands for services. In many communities, start-up funding to build community infrastructure is not available.

• Increasing demands have been placed on the public services system and local hospital emergency rooms as private insurance benefits for behavioral healthcare continue to deteriorate, Medicaid and insurance reimbursement rates fail to cover even direct costs for covered services, and the number of uninsured Virginians continues to increase. Some private providers are either closing beds or no longer serving publicly funded consumers because third party reimbursement rates do not cover the cost of providing their services. In addition, the overall number of inpatient beds has declined.

• The lack of health insurance parity for the treatment of mental illnesses and substance use disorders forces many persons who would seek private sector care to rely on the public system for treatment. Although fees are charged based on ability to pay, more expensive modalities, such as residential treatment, are underwritten by tax dollars.

• Across the services system, providers are experiencing difficulties recruiting and retaining qualified employees, particularly in highly marketable fields such as nursing and pharmacy. These difficulties will increase as the services system's current workforce grows older. The Department's existing workforce is aging, with an average age of 46 years for all positions and 49 years for nursing positions. Over 10 percent of Department employees will be eligible to retire in the next five years. Routine operations may be difficult to sustain as employees with historic knowledge and specialized skills are lost. Their replacements will come from a shrinking pool of healthcare workers.

• State hospitals and training centers are located in 12 geographic areas, with 412 buildings encompassing about 6.5 million square feet. The average age of all facility buildings is 49 years, with a median age of 55 years. The majority of occupied state facility buildings are in poor to very poor condition. Many state facility buildings are uninhabitable, require extensive renovation, or are not suited for current patient or resident needs. A significant capital investment is needed to bring these buildings up to required codes and therapeutic requirements.

• Virginia's public services system is affected by losses of other revenues previously dedicated to treatment for adult criminal justice (loss of SABRE funding) and juvenile justice (loss of Title IV-E funds) populations and by the upcoming closure of the Department of Juvenile Justice's Barrett Learning Center. The adult and juvenile justice systems are also experiencing reductions in funds that support their own treatment and other diversion activities. Juvenile Justice will soon be required to establish standards for community treatment, placing more demand on the public treatment system. Since CSBs try to serve these individuals, the loss of additional funding previously available from these systems further limits community treatment capacity.

• Fragmentation continues to exist across the agencies serving individuals with mental illnesses, serious emotional disturbances, mental retardation, and substance use disorders. Funding streams continue to be categorical, making it difficult to provide the flexibility needed to create choices among the services and

supports that promote self-determination and person-centered planning, empowerment, recovery, and resilience for individuals receiving services.

Agency Background Information

Statutory Authority

State Statutes

• Chapter 26 of Title 2.2 of the Code of Virginia establishes the Substance Abuse Services Council to coordinate the Commonwealth's public and private efforts to control substance abuse, requires the Office of Substance Abuse Services in the Department to provide staff assistance to the Council, and requires a Comprehensive Interagency State Plan.

• Chapter 53 of Title 2.2 of the Code of Virginia establishes the Early Intervention Services System to implement Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) and describes the lead agency's responsibilities. The Department is the lead agency.

• Chapter 11 of Title 16.1 of the Code of Virginia sets out the provisions of juvenile and domestic relations court law, including authorizing the Department to conduct evaluations of the competency of juvenile defendants to stand trial.

• Chapters 11 and 11.1 of Title 19.2 of the Code of Virginia authorize the Department to provide forensic services to individuals in the criminal justice system, including evaluations of competency, determinations of sanity, restoration to competency services, and treatment services for individuals adjudicated not guilty by reason of insanity.

• Chapter 2 of Title 37.2 of the Code of Virginia establishes the State Mental Health, Mental Retardation and Substance Abuse Services Board and outlines its duties and powers.

• Chapter 3 of Title 37.2 of the Code of Virginia establishes the Department of Mental Health, Mental Retardation and Substance Abuse Services under the supervision and management of the Commissioner. This chapter outlines duties and powers of the Commissioner, including supervising and managing the Department and its state facilities, which provide care and treatment for persons with mental illness and treatment, training, or habilitation of persons with mental retardation. State facilities also provide inpatient pharmacy services, geriatric services for elderly individuals, inpatient medical services, inpatient forensic services, education and training programs for school-age consumers, and facility administrative and support services. It also lists responsibilities of the Department, including the development of a six-year comprehensive plan.

• Chapter 4 of Title 37.2 of the Code of Virginia describes the protections available to consumers of mental health, mental retardation, and substance abuse services, including their human rights and the Department's licensing of providers, and establishes the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services.

• Chapter 5 of Title 37.2 of the Code of Virginia authorizes the establishment and operation of community services boards (CSBs) by local governments to provide community mental health, mental retardation, and

substance abuse services and authorizes the Department to fund CSBs.

• Chapter 6 of Title 37.2 of the Code of Virginia authorizes the establishment and operation of a behavioral health authority (BHA) by a specified city or county to provide community mental health, mental retardation, and substance abuse services and authorizes the Department to fund a BHA.

• Chapter 7 of Title 37.2 of the Code of Virginia authorizes the Department to perform certain functions related to the operation of state hospitals and training centers (state facilities) that serve individuals with mental illness or mental retardation respectively.

• Chapter 8 of Title 37.2 of the Code of Virginia addresses admissions and dispositions of individuals relative to facilities. It authorizes the Department or CSBs to provide drugs or medicines from funds appropriated to the Department for that purpose for consumers discharged from state facilities when they or the persons liable for their care and treatment are financially unable to pay for or otherwise access them (aftercare pharmacy services).

• Chapter 9 of Title 37.2 of the Code of Virginia authorizes the civil commitment of sexually violent predators, requires the Department to operate or contract for a secure confinement facility to provide behavioral rehabilitation services to them, and requires the Department to implement conditional release orders.

• Section 54.1-3437.1 of the Code of Virginia authorizes the Board of Pharmacy to issue a limited manufacturing permit to the pharmacy directly operated by the Department that serves consumers of the CSBs for the purpose of repackaging drugs.

Federal Statutes and Regulations

• Public Law 102-321 authorizes the federal Substance Abuse and Mental Health Services Administration to provide federal funds to the Department for community mental health services.

• The Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987 allow for preadmission screening evaluations and determinations for OBRA eligibility.

• Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) and 34 CFR 303.303.11-325 under the Individuals with Disabilities Education Act authorize the state to implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. The Individuals with Disabilities Education Act also defines who receives special education services in state facilities.

• Sections 1921-1954 of the Public Health Services Act authorize the federal Substance Abuse Treatment and Prevention (SAPT) Block Grant, providing federal funds to the Department for community substance abuse treatment and prevention services.

• The federal Centers for Medicaid and Medicare (CMS) certifies all ICF/MR beds in training centers operated by the Department and acute care beds and skilled nursing beds at the CVTC.

Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Customer Base:

Customer Description	Served	Potential
Adults served in state hospitals	4,410	5,628
Children and adolescents served in state hospitals	660	760
Children with mental retardation who need family support services	2,000	5,000
Citizens who make complaints about licensed providers that result in investigations	300	321
Community services boards and behavioral health authority (CSBs)	40	40
Consumers and family members receiving services from consumer-run programs, consumer and family education programs, or family-run support and education programs	2,249	5,000
Department of Corrections inmates meeting criteria as sexually violent predators (SVP) and eligible at release for SVP civil commitment	57	309
Governor (Office of the Inspector General Reports)	1	1
Individuals discharged from state hospitals and those diverted from state hospitalization to local acute care served by the Aftercare Pharmacy	8,875	8,875
Individuals meeting SVP criteria and civilly committed to the Virginia Center for Behavioral Rehabilitation (VCBR)	30	100
Individuals meeting SVP criteria and conditionally released for SVP treatment	5	45
Individuals served by nursing homes with mental retardation who are recipients of OBRA services	190	650
Individuals served by the Aftercare Pharmacy who are on community intake status	5,637	5,637
Individuals served by the Aftercare Pharmacy who have Medicaid drug coverage	1,916	2,000
Individuals served by the CSBs with mental retardation who are not eligible for MR Waiver or Part C early intervention services	10,147	11,147
Individuals served in state training centers	1,646	1,698
Individuals with active criminal justice system involvement who require secure forensic services	1,110	1,332
Individuals with mental retardation in community programs needing guardians who have guardians	0	200
Individuals with mental retardation served by or seeking services from CSBs	26,050	31,224
Individuals with mental retardation who need dental and other therapeutic services not currently available	418	10,000
Individuals with or at risk of serious mental illnesses or serious emotional disturbances served by or seeking services from CSBs	115,173	121,540
Individuals with substance use disorders served by or seeking services from CSBs	53,909	57,298
Infants and toddlers and their families served in Part C early intervention services	8,605	14,000
Juveniles requiring restoration to competency treatment services	83	104
Licensed providers of MH, MR, and SA services and developmental disability waiver services (including CSBs, other public, and private providers)	2,703	3,095

Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Customer Base:

Customer Description	Served	Potential
Local and regional jails	82	82
Members of committees and councils established or required by state or federal statutes or regulations staffed and supported by Department central office staff	525	525
Members of the General Assembly (Office of the Inspector General Reports)	140	140
Members, State Mental Health, Mental Retardation and Substance Abuse Services Board	9	9
Nursing homes	152	324
Participants in community prevention programs and coalitions	351,462	351,462
Patients at Hiram Davis Medical Center	173	184
Patients on state hospital medical/surgical units	495	520
Patients on the Central Virginia Training Center medical/surgical unit	234	246
Senior adults (65 and older) receiving services in state hospitals	662	749
State facility employees	9,000	9,000
State facility patients and residents receiving inpatient medical services in local hospitals through special hospitalization	541	591
State hospitals and training centers	16	16
Training center residents receiving vocational/educational services	1,018	1,130
Virginia criminal courts, including Juvenile and Domestic Relations Courts	120	120

Anticipated Changes In Agency Customer Base:

The Department anticipates the customer base for MH, MR, and SA services provided in community and state facility settings will continue to increase for a variety of reasons.

- Virginia's population is increasing, becoming more culturally diverse, and growing older. The customer base for MH, MR, and SA services will change to reflect these demographic trends.

- State facilities and community providers are already serving proportionately greater numbers of individuals with significant or complex service needs. State training center residents, particularly, will have serious medical conditions and physical risk factors. The number of state hospital patients with chronic medical conditions such as diabetes and hypertension will continue to increase. These individuals will require specialized health services, more medications, and ongoing preventive care.

- The frequency of individuals with co-occurring combinations of mental illnesses, substance use disorders, or mental retardation or other cognitive deficits, will increase, requiring more complex, specialized interventions and care.

- A growing number of Virginians have either limited or no MH insurance benefits that, too often, result in less than optimal treatment and care. These individuals will place increasing pressure the public services system.

- Limited affordable housing, insufficient numbers of residential treatment options, and the decreasing availability of local, acute inpatient beds will contribute to the Department's expanding customer base.

- Potential Code changes to lower the screening criterion for SVP eligibility could increase the number of sexually violent predators civilly committed to the VCBR and double the number of individuals who could be conditionally released to community treatment services.

- Increased numbers of juveniles receiving restoration of competency services also are anticipated.

- As CSBs purchase more local inpatient beds and develop community-based crisis stabilization services, increasing numbers of individuals will be eligible for Aftercare Pharmacy services. As a result of a recent agreement between the Department and the Department of Corrections, offenders with mental illnesses also will be eligible to receive Aftercare Pharmacy services.

- Anticipated significant increases in the number of private providers and service locations, including newly established brain injury programs, will affect the Department's ability to license programs and protect the safety and human rights of individuals receiving services.

Agency Partners:

Commitment Review Committee (CRC):

The Department's Central Office Conditional Release program staff serves on the CRC committee, which is operated by the Department of Corrections. The Department of Corrections screens SVP-eligible inmates for CRC review. The CRC reviews these cases and sends forward to the Office of the Attorney General those appropriate for SVP civil commitment.

Community Services Boards and Behavioral Health Authority (CSBs):

The Central Office allocates state and federal funds to the 40 CSBs to support the provision of community MH, MR, and SA services and supports. CSBs serve as the single point of entry into the publicly funded services system. They prescreen individuals for admission to state hospitals and training centers and prepare discharge plans. The Central Office regulates CSBs and works with CSBs to streamline licensing and other regulatory and reporting processes. CSBs participate in Central Office efforts to implement its mission and vision and have a voice in policy, planning, and regulatory development for the services system. The Commissioner enters into contracts with CSBs to provide juvenile competency evaluation and restoration services

Consumers, Family Members, and Advocacy Organizations:

Consumers, advocacy organizations, and consumer and family groups provide important feedback to the Department, the CSBs, and the state hospitals and training centers on service needs, services, and policy, planning, and regulatory development activity for the public services system. The Central Office meets with MH, MR, and SA advocacy organizations, and consumer and family groups to address issues of mutual concern. These organizations participate in Central Office efforts to implement its mission and vision and have a voice in policy, planning, and regulatory development for the services system. Some consumers and family members serve on CSBs. Consumer-run organizations provide very valuable services and supports for MH consumers and some advocacy organizations provide training and educatior for consumers and family members. State hospital and training center staff and CSBs work closely with consumers and family members in providing care, treatment, habilitation, and case management services. Consumers and family members are actively and meaningfully involved in all aspects treatment and discharge planning and community participation.

Federal Agencies:

The Department meets federal requirements associated with the receipt of block grants and other resources that support the provision of MH, MR, and SA services and for the development of services system capacity and technology. The Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services provides grants to the Department that support community MH and SA services. SAMHSA provides technical assistance to the Department and the CSBs about requirements associated the receipt of the grant funds. Similarly, the Office of Special Education Services (OSES) in the Department of Education provides grants of federal funds to the Department that support Part C early intervention services for infants and toddlers and their families. OSES also provides technical assistance to the Department on requirements associated with receipt of these grant funds.

Local Governments:

Because they establish CSBs, local governments have an important relationship with the Central Office through the CSBs. Local governments approve their CSBs' performance contracts that provide the basis for funding the CSBs. They also provide financial resources to the CSBs to match state funds, and, in some instances, may provide administrative services that are essential to CSBs' efficient operation. Through its licensing function, the Department works with local zoning, fire, health, taxation, social services and

Comprehensive Services Act officials to implement regulations and share information.

Private Providers (for profit and non-profit organizations):

Private providers are critical components of the publicly funded MH, MR, and SA system. They deliver a significant portion of community MH, MR, and SA services across the state through contracts with CSBs. Many private providers also deliver substantial amounts of Medicaid MR Waiver services to consumers pursuant to individualized plans of care developed and approved by CSBs, and all of these consumers receive Medicaid targeted case management services from CSBs. Local acute care hospitals are important providers of inpatient treatment purchased by CSBs through local bed purchases and by state facilities for patients or residents who require inpatient medical care. CSBs and the state hospitals work closely with local hospitals in coordinating admissions and discharges. CSBs, in cooperation with state hospital staff, plan, coordinate and monitor community residential placements in nursing homes, group homes and assisted living facilities to insure successful community transition and adjustment. The Central Office works with private providers to ensure that they meet licensing and human rights requirements. The Commissioner enters into contracts with private providers to provide juvenile restoration services and conduct post restoration evaluations of juvenile competency. Also through contracts with the Department, private community providers deliver sexually violent predator treatment, supervision, and monitoring services. Private providers also participate in Central Office efforts to implement its mission and vision and have a voice in policy, planning, and regulatory development for the services system.

Provider Associations:

The Central Office meets with provider associations to address issues of mutual concern. These associations participate in Central Office efforts to implement its mission and vision and have a voice in policy, planning, and regulatory development for the services system. Central Office Forensic staff work closely with the Virginia Sheriff's Association, the Virginia Association of Regional Jails and the Virginia Hospital and Healthcare Association in developing an agenda for positive change in the forensic program.

State and Local Agencies:

The Department works closely with many state and local agencies that provide or fund services and supports that respond to the needs of individuals with mental illnesses, mental retardation, or substance use disorders. These include partnerships with the Departments of Medical Assistance Services (DMAS), Social Services (DSS), Health (DOH), Rehabilitative Services (DRS), Housing and Community Developmen (DHCD), Corrections (DOC), Juvenile Justice (DJJ), Criminal Justice Services (DCJS), Aging (DA), and Education (DOE). Central Office and state hospital and training center staff work with the Virginia Office for Protection and Advocacy (VOPA) to ensure protections and advocacy for the human and legal rights of individuals with mental, cognitive or developmental disabilities. Department staff also work closely with the Department of Planning and Budget (DPB) around budget planning and finance expertise, with the Department of Accounts (DOA) in the receipt of accounting and processing services, financial reporting guidance and payroll expertise, and with the Department of General Services (DGS) around guidance regarding facility physical plant services. Partnerships with local agencies such as school systems, local social services, local health departments, and area agencies on aging are critical to the success of community MH, MR, and SA services. These include Medicaid MH services, MR Waiver services, auxiliary grants for adult living facilities, Medicaid eligibility determinations, various social services, guardianship programs, health care, vocational training, housing assistance, and services for TANF recipients. Some of these local agencies also participate in Part C LICCs and provide Part C services to infants and toddlers. State and local agency representatives participate as members of various state and regional planning committees, including the Special Populations Workgroups and Regional Strategic

Planning Partnerships focused on transforming the services system.

Virginia Institutions of Higher Education (Colleges, Universities, and Community Colleges):

The academic medical centers, academic programs of other colleges and universities, and community colleges work with the Central Office to collaboratively address workforce issues, to promote the implementation of evidence-based and other promising practices, and to train the services system's existing and emerging workforce. The Institute of Law, Psychiatry, and Public Policy at the University of Virginia provides training for juvenile and adult forensic evaluators and civil admission prescreeners and provides SVP civil commitment training. The Institute has partnered with the Department's Office of Forensic Services for more than 25 years to develop improved evaluation and treatment services for forensic clients and to promote outpatient approaches to service delivery.

Agency Products and Services:

Current Products and Services

Community MH, MR, and SA Services Provided by or Through CSBs:

A. Community Mental Health Services

- Emergency services, including crisis intervention and preadmission screening
- Local acute psychiatric inpatient services
- Outpatient services, including therapy and counseling, medication services, and intensive in-home services
- Assertive community treatment (PACT teams and ICT programs)
- Case management services
- Day treatment and partial hospitalization, including therapeutic day treatment for children and adolescents
- Rehabilitation services, including psychosocial rehabilitation programs
- Sheltered employment
- Group supported employment
- Individual supported employment
- Highly intensive residential services, such as crisis stabilization programs and residential treatment centers
- Intensive residential services, such as group homes
- Supervised residential services, such as supervised apartments, domiciliary care, and sponsored placements
- Supportive residential services, such as supported living arrangements
- Prevention services
- Early intervention services
- Consumer monitoring
- Assessment and evaluation services
- Consumer-run peer and support services
- Consumer and family member education and training activities

B. Community Mental Retardation Services

- Outpatient services, including behavioral management and consultation and medication services
- Case management services
- Habilitation services
- Sheltered employment
- Group supported employment
- Individual supported employment
- Highly intensive residential services, such as community ICF/MR programs
- Intensive residential services, such as group homes
- Supervised residential services, such as supervised apartments, domiciliary care, and sponsored placements
- Supportive residential services, such as in-home respite care and supported living arrangements
- Prevention services
- Early intervention services
- Consumer monitoring
- Assessment and evaluation services

- Medicaid targeted case management and MR Waiver services reimbursed by the DMAS
- Early intervention services for infants and toddlers under Part C

C. Community Substance Abuse Services

- Emergency services, including crisis intervention
- Local acute psychiatric inpatient services
- Community-based substance abuse medical detoxification inpatient services
- Outpatient services, including therapy, counseling, intensive outpatient, opioid detoxification, and opioid treatment
- Day treatment and partial hospitalization
- Rehabilitation services, including psychosocial rehabilitation programs
- Sheltered employment
- Group supported employment
- Individual supported employment
- Intensive residential services, such as primary care, intermediate and long-term habilitation, and group homes
- Jail-based habilitation services
- Supervised residential services, such as supervised apartments, domiciliary care, and sponsored placements
- Supportive residential services, such as supported living arrangements
- Prevention services, including community prevention coalitions
- Early intervention services
- Substance abuse social detoxification services
- Substance abuse motivational treatment
- Consumer monitoring
- Assessment and evaluation services
- Special projects (e.g., Co-Occurring Services Integration Grant (COSIG) and Strengthening Families)

Services Provided by State Mental Hospitals and Training Centers:

A. Inpatient Medical Services Products and Services

- Physician services
- Nursing services
- Skilled nursing care
- Special hospitalization (purchase of medical care from local hospitals)
- Pathology lab
- Radiology
- EEG/EKG
- Dental services and dental anesthesiology
- Speech and audiology
- Physical, occupational, and recreational therapy
- Ophthalmology services
- Respiratory therapy
- Psychology Services
- Medical supplies
- Detoxification

B. State Mental Health Facility Services
- Psychiatric assessment, stabilization and medication management
- Psychosocial rehabilitation programming, including psycho-educational services
- Psychology services
- Nursing services
- Social work services
- Recreational, physical and occupational therapies

C. State Mental Retardation Training Center Services
- Medical and psychiatric assessment
- Occupational, speech, physical, recreational therapies
- Short–term respite and emergency care
- Habilitation and skill acquisition for community integration
- Regional Community Support Center services and supports to individuals living in the community

D. Inpatient Geriatric Care Services
- Psychiatric and medical assessment
- Psychology services
- Nursing services
- Social work services
- Recreational, physical and occupational therapies
- Individualized treatment plans
- Medication management and rehabilitation
- Discharge planning and coordination

E. Facility-based Education and Skills Training
- Pre-vocational skills
- Habilitation services
- Sheltered workshop
- Work readiness training
- Community based employment
- Functional academics based on the consumer's Individual Education Plan.

F. Forensic and Behavioral Rehabilitation Security

Forensic Services
- Expert inpatient and outpatient mental health evaluations and reports for the courts
- Emergency treatment services
- Treatment to restore competency to stand trial
- Commitment for treatment for individuals acquitted of a criminal offense as Not Guilty by Reason of Insanity
- Expert court testimony in forensic matters
- Statewide training in forensic MH evaluations for the criminal courts
- Coordination with CSBs of public community MH services for forensic consumers
- Training, consultation, and assistance on forensic issues

SVP Behavior Rehabilitation Services
- Sex offender rehabilitation services within a maximum-security perimeter

- Review of CRC and SVP evaluations
- Quality management feedback to CRC evaluators
- Annual SVP commitment reviews for the courts

Pharmacy Services

A. Aftercare Pharmacy Service Area Products and Services

- Medication management -- dispensing, preparation, packaging, compounding, labeling and mailing
- Provision of drug and medication information to CSBs, consumers, and family members
- Utilization of cost containment methods, including the "Medsavers" program
- Participation in the Department's Pharmacy, Therapeutics and Formulary Committee
- Participation in the development of a Behavioral Quality Indicator program

B. Inpatient Pharmacy Service Area Products and Services

- Medication selection and procurement
- Medication management and education
- Service oversight and cost containment
- Medication preparation and dispensing

Facility Administrative and Support Services

- Administrative leadership and regulatory compliance
- Information technology support
- Food services for state facility patients and residents
- Housekeeping services to ensure a clean and safe environment
- Linen and laundry services
- Physical plant services, including building maintenance and security services
- Power plan operations
- Employee training and education services

Central Office Administrative and Support Service Area Products and Services

A. Policy, Legislation, Strategic and Comprehensive Plans, and Studies:

- State Board and operational and programmatic policies, regulations, and guidance documents
- Legislative analysis, proposal development, and studies
- Strategic, comprehensive, and continuity of operations plans
- Consumer surveys
- Staff support to boards, councils, and committees established in state or federal requirements

B. Consumer Protections:

- Human Rights investigations and reports
- Criminal background checks for prospective state facility and certain community employees

C. Services System and Program Development and Oversight:

- Training and technical assistance and general guidance to CSBs, state facilities, and providers
- Performance Contracts with CSBs that fund services
- Medicaid MR Waiver pre-authorization of services
- Nursing home pre-admission screening and resident reviews (PASRR)
- Terrorism and disaster preparedness, response, and recovery operations

- Compilation and analysis of service data and quality indicators
- Grant application development and implementation of grant-funded projects
- Quality assurance reports

D. Agency Operations:
- Financial management, reporting, and allocation and disbursement of state and federal funds
- Development of Central Office contracts and business agreements
- Revenue collection
- Internal audits, audits of data and reports, and compliance reviews
- Information technology systems development and support
- Workforce management, recruitment, training, and development
- Risk management and HIPAA compliance
- General support services for Central Office operations (mail, parking, procurement)

E. Management of the SVP Conditional Release Program:
- Development of conditional release safety and treatment plans
- Training to expand community treatment capacity
- Recruitment, training, and management for community conditional release treatment teams

F. Supervision of the Juvenile Competency Restoration Program:
- Juvenile Forensic Evaluation and Juvenile Competency Restoration procedures
- Arrangements for Competency to Stand Trial restoration treatment services
- Administration of fee for services contracts with CSBs and private providers
- Technical assistance, training, supervision, oversight, and general guidance to services providers
- Quality assurance and compilation of service data and quality indicators

G. Architectural and engineering services (State facilities and Woodrow Wilson Rehab. Center):
- State facility capital master plans
- Oversight of facility capital projects' design and implementation
- Energy audits

Regulation of Public Facilities and Services Products and Services
- Issue new licenses and renew licenses of MH, MR, SA, developmental disability, and waiver services providers
- Unannounced monitoring of licensed services
- Complaint investigations of licensed services
- Receive and review data on serious injuries and deaths in services
- Revocation and sanction actions against licensed service
- Information to the public about licensed providers
- Verification to payment sources (DMAS and DSS) that a provider is licensed
- Training of applicants to become licensed

Facility and Community Program Inspection and Monitoring (Office of the Inspector General)
- Reports of findings and recommendations regarding the quality of services that result from inspections of facilities operated by and programs licensed by the Department.
- Investigations of complaints regarding abuse, neglect and quality of services

- Consultation to state facilities and licensed programs regarding compliance with OIG recommendations
- Review of Department instructions and regulations
- Support to the Office of the Governor and the General Assembly, as requested

Factors Impacting Agency Products and Services

Factors Affecting Community Mental Health, Mental Retardation and Substance Abuse Services

• Demand for community MH, MR, and SA services is expected to increase as the Commonwealth's population grows.
• The President's New Freedom initiative, along with ongoing Olmstead concerns, will continue to emphasize the development of community services. However, possible federal efforts to reform Medicaid could have potentially catastrophic effects on the provision of community MH and MR services, in terms of services covered, eligibility of individuals, and the financial impact of any Medicaid reform on other parts of the state's budget. Any additional constraints on eligibility or covered services would increase the demand for and reliance on CSB services. Additionally, the implementation of Part D of the Medicare program could have unintended or unknown but potentially very significant consequences for individuals receiving community services.
• The increased costs of providing services without corresponding increases in state and federal funds will result in the provision of fewer MH, MR, and SA services to fewer individuals and an increased unmet demand for services. Absent or inadequate increases in base amounts of state or federal funds to support the normal ongoing costs of providing services, such as cost-of-living increases, or to address unavoidable increases in operating expenses, such as the escalating costs of existing and new psychotropic medications, have adversely affected the capacity of CSBs and private providers to maintain current levels of services. It appears that the federal government intends to reduce the level of ongoing block grant funding that it provides to the states for community MH and SA services.
• The absence of adequate reimbursement rates for Medicaid State Plan Option and Medicaid MR services will continue to make it increasingly difficult to sustain essential core services offered by CSBs and private providers. This will increase the demand for and reliance on CSB services that are supported only with state, local matching, or federal funds. Inadequate reimbursement rates and the resulting lack of available cost-effective community services mean consumers in some instances end up using higher cost services instead.
• The decreasing availability of adequate health insurance coverage for the treatment of mental illnesses and the increasing numbers of individuals without health insurance who do not qualify for Medicaid will increase the demand for services provided by CSBs that are supported with only state, local matching, or federal funds. The lack of parity in Medicaid and other insurance coverage for SA services also increases the demand for and reliance on CSB services that are supported only with state, local matching, or federal funds.
• The decreasing availability of qualified professionals, particularly direct care staff, makes it more difficult for CSBs and private providers to maintain or expand existing services or develop new services to address unmet demands for services, to deliver quality services, to maintain the most challenging persons in the community, or to adopt or develop new service modalities or approaches, such as evidenced-based practices. For example, there is a growing need for community-based practitioners of positive behavioral supports. A better trained and a more stable direct care work force is a critical need throughout the state at all service levels.

• Improved assessment and screening of adults and children with co-occurring mental illness and substance use disorders or co-occurring mental retardation and mental illness or mental retardation and substance use disorders will increase demands for integrated services to treat these co-occurring conditions.
• Increasingly complex and burdensome federal requirements to report treatment and prevention outcome data decrease the staff resources available to provide direct clinical services. For example, the federal National Outcome Measures will require CSB to collect and report outcome measures in at least six domains for both MH and SA.
• The inability to communicate HIPPA-sensitive information electronically between the Department and all providers slows processes of service authorization and incident reporting.
• A new federal emphasis on the development and support of services provided by faith-based organizations may affect current service providers and introduce significant complexity into the administration, management, and provision of community SA services.
• A persistent lack of residential treatment services capacity adversely affects the services system's ability to address unmet service needs.
• All community SA prevention services are supported by federal block and competitive grants. Lack of state funds inhibits the ability of the services system to provide all of the prevention programs that are needed and would have a significant impact on the reduction of substance use disorders and their associated services costs.
• Increased state and federal emphases on identifying and serving substance-exposed newborns, substance-affected children, and their families involved with the child welfare system and juvenile and domestic relations courts will increase service referrals and introduce increased needs for collaboration, care coordination, and training across systems.

Factors Affecting Services Provided by State Hospitals and Training Centers

• As the Department invests in community services and rigorously screens and continuously reviews the acuity and level of functioning of state hospital patients to ensure that inpatient services continue to be needed, demand for inpatient beds is expected to decrease. This decrease could be offset by increased demands resulting from population growth, continued reductions in the number of local hospital psychiatric beds statewide, inadequate financial support to develop community crisis stabilization and intensive community treatment, lack of available and affordable housing and residential treatment options, and further deterioration in mental health insurance benefits. The lack of integrated community treatment for persons with co-occurring mental illness and substance use disorders or co-occurring mental retardation and mental illness or mental retardation and substance use disorders also could increase demand for state hospital services.
• Future demand for state training center services will be decreased by the increased availability of community MR services and supports, including MR Waiver group homes, community ICF/MR facilities, and behavioral consultation and medical, dental, and other services provided through the Regional Support Centers.
• Demand for secure forensic evaluation and treatment services is anticipated to increase as the population grows, resulting in more people on waiting lists for admission to secure units and longer wait times. Demand for secure forensic services may be offset by the manner in which community MH agencies, law enforcement, and the courts respond to the behaviors of individuals with mental illness in community settings. The lack of community MH crisis intervention and crisis stabilization services and the complexity of arranging inpatient treatment for individuals in crisis often result in individuals being

arrested and incarcerated, in lieu of community-based or state hospital treatment. Once arrested, individuals with mental illness often require a year or more of inpatient treatment to render them able to stand trial for criminal charges that could have been avoided if a jail diversion approach were available.
• If the screening criterion for SVP eligibility is lowered, accelerated growth in the numbers of sexually violent predators civilly committed to the VCBR and conditionally released to community treatment services would increase the risk for harm and injury among VCBR residents and staff, increase the Department's liability for damages, and degrade critical SVP treatment service resources.
• Gradual declines in the census of state facilities and increased emphasis on medical screening to ensure that complex medical problems of individuals are addressed in local hospitals prior to their admission to a state facility have the potential to decrease utilization of facility medical/surgical units and to reduce the costs associated with outpatient medical services and special hospitalizations in local acute care hospitals purchased by state facilities.
• The reluctance of elderly individuals to seek mental health treatment and the poor service coordination among agencies providing services to this population often results in a more complicated clinical picture when a person finally does present for services. Slightly less than four percent of the consumers served by CSBs are elderly, despite the fact that over 16 percent of the state's population is older adults. This reluctance to seek treatment early, coupled with the insufficient availability of specialized services and expertise in CSBs and the lack of a focal point in the Department to collect reliable data needed for program planning and to facilitate the development of gero-psychiatric services may increase demand for inpatient services.
• The cost for facility-based education and skills training education services and associated materials are expected to continue to increase, as will the cost to transport individuals to off-campus instruction services. Public school program costs, paid by the state facility to local public schools if the consumer's needs are best met there, will continue to increase.
• The current poor condition of state facility buildings will require signification infrastructure investment and replacement.
• Clinical, environmental, and administrative standards set by the Centers for Medicaid and Medicare (CMS) and by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) are likely to continue to become more complex, burdensome, and more expensive to implement.

Factors Affecting Pharmacy Services

• Demand for Aftercare Pharmacy services will increase as local inpatient purchase of service options and community crisis stabilization capacity is increased. Increasingly, individuals receiving Aftercare Pharmacy services are requiring numerous changes in medication regimens and much faster response and turnaround times.
• The growing number of individuals who are medically uninsured or underinsured results in unrecoverable medication costs to the Commonwealth.
• Rising medication costs are dramatically affecting pharmacy services. Prescription drugs are the fastest growing segment in health care expenses in the United States. Psychotropic medications account for more than $ 60 billion nationally in annual sales from pharmaceutical companies. As new, more effective but expensive medications are introduced and prescribed, direct pharmaceutical costs will continue to increase.
• In Virginia and nationally, there is a pharmacist shortage. The Department's pharmacist salaries are the lowest in the state, making recruitment and retention of pharmacists extremely difficult.
• The Department must comply with the recent federal mandate to implement bar codes, effective April

26, 2006.
• The current state facility pharmacy computer system was purchased in the 1980s and is outdated and inadequate. The system is unable to communicate with other data systems, most significantly the department's current billing system and patient demographics database.

Factors Affecting Administrative and Support Services (Central Office)

• The average age of the Central Office workforce is just under 52 years old and the average length of Central Office employees' state service is almost 18 years. Almost 15 percent of Central Office employees will be eligible to retire in the next five years. This level of turnover, especially in key positions, could significantly affect Central Office operations.
• New requirements in Governor's Executive Orders and changes in regulations from external agencies such as DOA, DHRM, DPB, DGS, and VITA. Additional workload requirements, often unfunded, from federal or state agencies could affect Central Office administrative and support services.
• Changes in economic conditions affecting the Commonwealth may limit the ability of the Central Office to hire the number of staff needed to accomplish the objectives of the service.
• Central Office administrative and support services also may be affected by new federal performance measurement requirements and the implementation of VITA's standards for production application information technology systems.
• Consumers and advocacy group issues also could affect Central Office operational priorities, strategic and comprehensive planning, and policy and regulatory development activities.

Factors Affecting Facility Administrative and Support Services

• The workforce of state facilities is aging just as the state workforce in general. This is particularly true of the facility workforce for facilities in rural areas where staff turnover is less than in more urban areas. Recruitment and retention of the facility workforce of the future will be a challenge.
• New requirements in Governor's Executive Orders and changes in regulations from external agencies such as DOA, DHRM, DPB, DGS, and additional workload requirements, often unfunded, from federal or state agencies could affect state facility administrative and support services. Changes in the Departments regulations related to human rights also could affect state facility administrative and support services.
• Individuals with more complex and severe medical disabilities will place additional demands on facility support services such as special diets, additional laundry services, more frequent housekeeping, and specialized safety and security.
• Changes in economic conditions affecting the Commonwealth may limit the ability of facilities to hire the number of staff needed to accomplish the objectives of the service.
• Facility administrative and support services also may be affected by the rapidly changing healthcare environment, annual increases in health care costs, facility relationships with VITA and implementation of technological changes such as the electronic health record, and future potential outsourcing of state facility administrative and support functions.
• Facility building renovation needs driven by building or life safety code changes and aging capital equipment also could affect facility administrative and support functions.

Factors Affecting Regulation of Health Care Service Providers

• New or revised federal and state statutes and regulatory or funding requirements affecting licensing of MH, MR, and SA services and DD Waiver services
• Increased demands resulting from development of new MH, MR, and SA services and DD Waiver services licensed by the Department
• Licensing staffing levels and competitive pressures affecting recruitment and retention of new staff
• Consumers and advocacy group issues
• Information technology changes
• Media or community attention to licensed services as a result of serious incidents or community concerns.

Factors Affecting Facility and Community Inspection and Monitoring (Office of the Inspector General)

• Federal Department of Justice (DOJ) expectations regarding ongoing compliance by the state facilities with DOJ-VA settlement agreements
• The gradual downsizing of state facilities and increase in the severity and complexity of consumers' needs
• The shift of care for many consumers with severe disabilities to the community
• An increase in the number of community-based public and private providers
• Limited staffing with which to carry out the responsibilities established in the Code of Virginia.

Anticipated Changes in Agency Products and Services

Anticipated Changes in Community MH, MR, and SA Services

• The Department's ongoing collaborative efforts with CSBs and other stakeholders to transform the public MH, MR, and SA services system will increase the need and demand for existing and new types of community services as state facility capacity continues to be reduced gradually and community service capacity is increased.
• Improved early screening, assessment, and clinical practice patterns will allow for more efficient, effective interventions to greater numbers of consumers and improved treatment outcomes.
• As part of this transformation, CSBs and regional consortia of CSBs need to acquire the requisite capacity to manage their utilization of state facility and community inpatient psychiatric beds. This will require increased staff and infrastructure to conduct extensive and complex utilization management and review activities, but this activity will result in much more effective and efficient use of expensive and scarce state and local hospital beds.
• Federal block grant requirements and the National Outcome Measures will require that CSBs offer evidence-based treatment and prevention programs and practices. The identification and adoption of evidence-based or consensus-determined best practices, such as assertive community treatment, supported employment, illness management, recovery services, multi-systemic therapy, functional family therapy, and systems of care for children and adolescents with serious emotional disturbances, will require additional resources to implement, monitor, and evaluate these practices and services.
• Changes in the infrastructure from a more facility-based system of care to a system of more community services and supports will continue to cause dramatic increases in the number of licensed providers. This increase in new providers and emerging evidence-based practices will require increased demand for training personnel in order to maintain minimum standards of quality.

Anticipated Changes in Services Provided by State Hospitals and Training Centers

• Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Centers for Medicare and Medicaid Services (CMS) standards will continue to emphasize the provision of person-centered active treatment. The increasing complexity of the agency's inpatient population, in state hospitals and state training centers, will require a well-trained workforce that is kept current with best clinical practices.
• Nationally, JCAHO is expecting healthcare organizations to increase use of information technology such as electronic health care records to improve staff clinical communication and quality assurance and reduce medication errors. In addition, cost containment efforts regarding medication and monitoring of service quality will require increased computerization.
• Utilization of telecommunication for clinical consultation to isolated or distant community providers is likely to increase.
• Both JCAHO and CMS will continue to increase inpatient standards for environmental safety. State facility buildings must be appropriate to consumer needs, and they must meet 2000 Fire/Life Safety Standards.
• Facility buildings at all training centers must be replaced over the next three biennia due to their extreme age, poor plant condition, and inappropriateness to consumer needs. The Department is proposing implementation of the MR Services and Supports Options by Level of Care (the MR Model) developed by the MR Special Populations Workgroup. The MR Model would replace the training centers with smaller, appropriately designed and efficient Intensive Support Centers (ISCs) and small Intensive Support Homes (ISHs) operated by the ISCs. Successful implementation of this model will require investment in an extensive array of flexible community-based service options, including enhanced and improved community MR Waiver and family supports, community ICF/MRs ,and MR Waiver group homes. The ISCs or state medical schools would operate Regional Community Support Centers that would be open for persons from the community to receive dental, behavioral, medical, and other clinical services.
• Reliance on information technology will increase for internal center operations and quality assurance monitoring and clinical services. To support services to persons in rural areas and areas with inadequate public transportation, use of telemedicine and telepsychiatry for long-distance case consultation is likely to expand. Technology and software must be kept current.
• The Department will monitor the appropriateness of bed utilization in medical/surgical units and the actual number of bed days in comparison to the projected bed days to determine the most cost effective means of providing medical/surgical and skilled nursing services.
• The Department and its partner agencies will work to improve the current process of managing the care provided to individuals with mental illness who become involved with the criminal justice system in Virginia.

Anticipated Changes in Pharmacy Services

• The Food and Drug Administration published a final rule on Bar Code Label Requirements on certain products dispensed from pharmacies. The Joint Commission on Accreditation of Healthcare Organizations is poised to require accredited organizations to implement bar code technology to help identify patients receiving medications and improve patient safety.
• The atypical antipsychotic class of medications has recently been shown to effectively control manic symptoms of bipolar disorder, as well as offer a superior side effect profile compared to older agents.

The FDA's approval of these drugs in alternative disease states (bipolar disorder, etc.) is expected to further increase the utilization within this class of drugs.

Anticipated Changes in Administrative and Support Services (Central Office)

• The Central Office will implement training that increases the knowledge and skills of staff in all levels of state facilities and community providers about implementing recovery, resilience, and person-centered principles and practices.
• Central Office human rights activities will increase as the number of MH, MR, and SA service providers continues to grow. The Central Office will conduct more human rights related investigations.
• SVP Conditional Release service needs will increase each year as more individuals meeting the criteria as sexually violent predators are conditionally released, have their probation or parole obligation end, or are released from the Virginia Center for Behavioral Rehabilitation.
• The number of court orders for juvenile competency restoration issued per annum has doubled since FY 2000 and is expected to continue to increase.
• The Central Office will establish and implement a cross-agency system for consistent collection of data from non-behavioral health agencies describing the services and supports they provide to individuals in their systems with mental illnesses, mental retardation, or substance use disorders.
• The Central Office will conduct more program and utilization reviews and financial and compliance audits to ensure accountability and compliance with federal and state statutes and regulations.
• The Central Office will adopt and promote through training, consultation, and technical assistance, evidence-based, best and promising practices that incorporate recovery, resilience, and person-centered principles and practices.
• The Central Office will develop state-of-the-art information technology systems to meet current management, monitoring, and compliance needs. It will establish a data collection and analysis capacity for quality assurance and improvement and performance measurement activities.

Anticipated Changes in Facility Administrative and Support Services

• Other than the potential privatization of specific services, no major changes in state facility administrative and support services are anticipated.

Anticipated Changes in Regulation of Public Facilities and Services

• As the number of services providers grows, the Central Office will issue more licenses and will conduct more licensing and human rights related investigations. To increase efficiency, the Central Office will establish a centralized call center for human rights and licensing complaints.
• The joint legislative study of child and adult group homes may result in increased demands on licensing services in terms of monitoring, sanctions, and negative actions.
• Increased focus on community services may increase likelihood of investigations by VOPA or media, which affects and generally increases licensing monitoring.

Anticipated Changes in Facility and Community Program Inspections and Monitoring (Office of the Inspector General)

• On a pilot basis during FY 2006, the OIG is beginning to conduct inspections and reviews of licensed

community-based programs operated by community services boards and private providers.

• The OIG will begin to focus more inspections of state facilities on topical areas that enable a targeted look at specific functional areas rather that broad-based reviews of the facilities.

Agency Financial Resources Summary:

Department of Mental Health, Mental Retardation, and Substance Abuse Services funding comes from state general funds, special revenue funds, and federal grants. State general funds support the Department's sixteen inpatient facilities, finance the majority of the Central Office oversight functions, and fund community programs operated by Virginia's CSBs and several private not for profit organizations.

Special Revenue funds are derived predominantly from the collection of fees related to the provision of services in the Department's inpatient facilities. These revenues consist of Medicaid reimbursement, Medicare reimbursement, private insurance reimbursement, private payments, and other federal entitlement programs.

Federal funds consist of numerous grants from the federal government. The majority of the Department's federal funds consist of the Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant, which are passed through to community services board programs. With the exception of the National School Lunch, National School Breakfast, Education of Handicapped Children, and Virginia Department of Agriculture and Consumer Services Federal Food Distribution Program, all grants are passed through to community programs. Those not passed through are administered by some of the Department's 16 state facilities.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$458,455,702	$317,189,215	$457,808,280	$317,836,637
Changes To Base	$55,368,323	$17,732,690	$68,157,796	$9,801,518
AGENCY TOTAL	**$513,824,025**	**$334,921,905**	**$525,966,076**	**$327,638,155**

Agency Human Resources Summary:

Human Resources Overview

The Department of Mental Health, Mental Retardation and Substance Abuse Services depends on a full complement of salaried, wage, and contract employees (approximately 9,700) in a wide variety of classifications (over 125 roles) to provide the necessary services to its customers.

On June 1, 2005, the Department's Central Office had a total human resources level of 263, of which 248 were full time classified positions.

The vast majority of Department employees provide direct services to individuals in state facilities, which operate 24 hours a day, seven days a week. Additionally, a considerable number of Department employees provide site support services necessary to maintain the infrastructure and surrounding environments of the 16 state facilities and to operate the facilities' physical plants.

A demographic profile of the total Department workforce shows the following characteristics:
- Race: 47.8 percent Caucasian 52.2 percent minorities
- Gender: 75.1 percent female 24.9 percent male
- Average Age: 46.4 years
- Average Length of Service: 13.0 years

Approximately 43 percent of the Department's total workforce is employed as direct service associates. The demographic profile of this segment of the workforce shows the following characteristics:
- Race: 32.5 percent Caucasian 67.5 percent minorities
- Gender: 81.2 percent female 18.8 percent male
- Average Age: 43.5 years
- Average Length of Service: 11.6 years

This diversity of staffing skills mix, the complexity of consumer service requirements and facility and site support issues have posed a number of human resources challenges, including:
- The aging and increasing cultural diversity of the current workforce,
- Declining enrollments in key degree and specialty programs such as nursing,
- The shortage of health care professionals and direct care workers, and
- The increasing level of skills expected of the workforce in the future.

Full-Time Equivalent (FTE) Position Summary

Effective Date:	6/1/2005
Total Authorized Position level	9842
Vacant Positions	1089
Non-Classified (Filled)	4
Full-Time Classified (Filled)	8722
Part-Time Classified (Filled)	61
Faculty (Filled)	0
Wage	753
Contract Employees	143
Total Human Resource Level	**9683**

Factors Impacting Human Resources

As Virginia's population increases and demands on the publicly funded MH, MR, and SA. services system increase, several major factors are expected to affect the quality, responsiveness, and effectiveness of the system's human resources.

- The average age of the Department's current workforce continues to increase. This trend is expected to continue over the next six years. The average of the Department's current workforce of nearly 10,000 employees is now 46 years old. The average age of Department nursing positions is now 49 years old.

- Just over 10 percent of the Department's workforce will be eligible to retire in the next five years and in some facilities, this increases to 14 percent to 17.1 percent, many in this group are nurses. This loss of experienced and well-trained staff could have an adverse effect on patient care and safety. Significant

recruitment and succession planning will be required for many occupational groups.

• Demand for health care workers generally is slated to increase by 115 percent in 2005, creating a highly competitive market for public sector entities. Across the services system, providers are experiencing increasing difficulty in recruiting and retaining clinical and direct care workers with the requisite health care skill sets and core competencies who are interested in pursuing careers in the public sector.

• Department vacancy and turnover rates continue to increase while available workforce resources decline. The exhaustive effort of recruitment and retaining staff with lagging compensation and inadequate career mobility opportunities has resulted in a revolving door scenario, creating extensive overtime and limiting the Department's ability to be a viable competitor in the marketplace. While the Department is evaluating alternative or non-traditional training and educational programs for nursing and direct care staff, this will not be sufficient. Additional resources will be needed if the Department is to successfully recruit and retain a workforce with the skills necessary to address the needs of individuals served by its facilities.

• New technologies and increasing service demands will create a health care market that requires highly skilled and well-educated workers. In addition to technical or clinical skills and expertise, well-honed communication and reasoning capabilities will be needed.

Anticipated Changes in Human Resources

• Demand for jobs in seven of the 25 fastest growing occupations will be in health care positions utilized within the MH, MR, and SA services system. These include: personal and home care aides, nurses, physical therapists, residential counselors, human services workers, teachers of special education, and other health service workers.

• To expand the pool of workers, the services system at all levels must begin to adapt to a situation in which workers in general, and particularly skilled and motivated workers, are likely to be in short supply. The Department's vacancy and turnover rates are expected to continue to increase while the general availability of workforce resources declines. This will likely exacerbate staffing shortages and increase demand for overtime.

• It will be necessary to increase compensation to attract, retain, and motivate individuals into the system and encourage higher productivity of existing employees by providing incentives more closely connected to performance. Competitive base salaries complemented by the use of bonus systems that reward employees for demonstration of desirable behavior and the application of needed competencies is necessary.

• Training is important to employee satisfaction, productivity, and growth. As increasing numbers of employees retire, many of the new workers who replace them will require training to develop needed core competencies. Workforce training in new service technologies and evidence-based practices also will be critical to increasing the productivity of existing employees and maintaining the quality of services. Such training can occur through tuition reimbursement, web based distance learning, and on-site formal education.

• Career progression and pathways also will be critical to recruit and retain health care and direct

support professionals. Career ladder models that support employee advancement through the attainment and application of successively higher levels of competencies will be increasingly important. Employees who can create and apply sophisticated new technologies will be rewarded.

• A more detailed breakdown of human resources, issues, and initiatives can be found in the Department's Human Resources Development and Management's Workforce Plan from the Office of Human Resource Development and Management (See http://www.dmhmrsas.virginia.gov/WDI/)

Agency Information Technology Summary:

Current State / Issues

• The Department maintains 24 production application information technology systems, among them:

-- The state facility consumer information system (AVATAR), which was developed in 2003 to ensure compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Sets Privacy Rule, is in production and producing monthly reimbursement billing on schedule.

-- The Department, in partnership with the CSBs, has successfully implemented the community consumer submission (CCS) extract software, which enables the Department to comply with federal and state reporting requirements. The software and database were modified to support reporting of new data items. A project to re-architect the entire data reporting process for CSBs was initiated in March 2006 and is scheduled to be completed in December 2006.

-- The FMS Migration from the HP3000 platform to Windows/SQL Server is 80 percent complete and is scheduled to be completed by June 30, 2006.

• The HIPAA Security Rule implementation is behind schedule. The Departmental Instruction relating to Security has been issued. An agency security officer position to manage the technology security program has been established and will be filled by May 15, 2006. Central Office and facilities continue to work on developing procedures to conform to the security position.

• The Department's ITS Office currently has 15 classified positions, one contracted position, and two P-14 positions. One of the 15 classified positions is vacant but recruitment to fill is underway. These positions support application development activities in the Central Office and in state facilities. The Department currently has two applications that are in active development. Three are in the analysis phase and one is in final user testing. Five of these projects have (or will have) objective outcome measures (project plan, monitoring, scheduling, and budget) and are or will be utilizing best business development practices (primarily VITA standards). The remaining project has not followed VITA standards.

• Currently there are no measures that are formally in place to track productivity in ITS. Processes to develop best business practices and procedures that comply with VITA standards for new projects and application maintenance activities continue. These practices and procedures will address measures for productivity and documentation requirements for project planning activities. They include or will include:

- System Development Life Cycle (SDLC) - Completed
- Project Charter - Completed
- Documentation requirements for each phase of the SDLC - Completed
- Project Planning Requirements - Under development (March 2007)
- Customer approvals - Completed
- Progress reporting - Under development (December 2006)
- Change control - Under development (June 30, 2006)
- Security - Under development (December 30, 2006)
- Testing - Under development (June 30, 2006)

• A standard automated problem and resolution tracking system was put into production for several applications in September 2005. Starting April 3, 2006, problems and issues related to all supported applications are being tracked with this system.

• Currently, there are no processes in place to assist in measuring how well ITS staff achieves desired outcomes. However, several active projects are one to two years behind the proponent office expected delivery date and satisfaction is low. Business customer surveys have not been conducted. Service level agreements for services are not in place.

• The Department's technology environment and staff are transitioning from supporting legacy applications using older technologies to developing and supporting new applications using current technology. This includes development of a structured applications development environment, standardization of development tools, and provision of adequate training and support for the technology staff.

• Technology resources are being restructured for applications development and support following the transitioning of a staff to VITA in 2004. For both the central office and state facilities, this change has brought about significant challenges. Supporting the out-of-scope services has frequently been difficult.

• Applications within the Department are not well integrated. This impairs data reporting and analysis efforts as well as applications maintenance and enhancements that must be done by technology staff. Also, a significant amount of state facility data must be migrated from an obsolete hardware platform so that critical reporting functions will not be interrupted. Two opportunities for integrating stand-alone applications with AVATAR have been identified.

• The Department’s technology infrastructure requires upgrading. A number of facilities need to upgrade hardware, software, and network cabling. Supporting this infrastructure is very difficult.

Factor Impacting Information Technology

• Federal reporting requirements for outcome measures will require changes to the Department's MH, MR, and SA information technology services applications.

• Federal requirements for an electronic heath record are being considered. These requirements would impact technology needs in state facilities and CSBs.

• Requirements for medication management will require the Department to upgrade or replace its automated pharmacy system in the state facilities and Aftercare Pharmacy. This includes medication bar coding.

• Security management (HIPAA, Homeland Security) will require additional resources in the central office and in state facilities.

Anticipated Changes / Desired State

• The Department will develop a strategic technology vision and plan for the agency to guide the Department and the CSBs. It will provide a statement of what culture of data means within the mental health, mental retardation, and substance abuse services system and how data can be used as a ally and valuable resource for fulfilling the vision of a consumer-driven system of services based on self-determination, empowerment, recovery, and resilience.

• A structured information technology applications development environment will be established. This will include employing standard development and maintenance procedures and a standard set of development tools. Staff training and retraining will be a priority. This effort should result in more consistent applications that lend themselves to better integration and a more productive staff. This effort will also address some of the issues created by the VITA transition.

• The Department will design and develop a set of applications to address the outcome measurement requirements for MH, MR, and SA services. These applications will be integrated with the community consumer submission (CCS) application.

• A project will be initiated to upgrade for replace existing pharmacy applications in the state facilities and in the Aftercare Pharmacy to meet requirements.

• A project will be initiated to obtain an application to meet the requirements of the electronic health record.

• Resources will be identified or obtained to support the security management process. This will free current resources to address issues related to supporting out-of scope services.

• Enhancements to data reporting and analysis processes to integrate data from multiple sources will be made, such as data warehousing and data migration from obsolete platforms.

Agency Information Technology Investments:

	Cost-Fiscal Year 2007		Cost-Fiscal Year 2008	
	General Fund	**Nongeneral Fund**	**General Fund**	**Nongeneral Fund**
Major IT Projects	$0	$100,000	$0	$100,000
Non-Major IT Projects	$0	$175,000	$0	$175,000
Major IT Procurements	$0	$0	$0	$0
Non-Major IT Procurements	$0	$0	$0	$0
Totals	**$0**	**$275,000**	**$0**	**$275,000**

Agency Capital Investments Summary:

Current State / Issues

The Department operates 16 facilities located in 12 geographic areas, with 412 buildings encompassing about 6.5 million square feet. The average age of all state facility buildings is 49 years, with a median age of 55 years. Maintenance and renovation funding has not been adequate to prevent a gradual decline in the condition of state facilities over the years. Most buildings require replacement of their HVAC, fire alarm and electrical systems and are generally in poor condition.

Factors Impacting Capital Investments

• State hospitals and training centers will continue to be essential components of Virginia's publicly funded services system. The Department is committed to achieving a best practices balance between community and state facility services. As such, the Department must ensure that state facilities are safe, efficient, well maintained, and appropriately designed to meet the needs of patients and residents receiving services.

• Over the past decade, the census of most state facilities has dropped. State facility programs and consumer profiles also have changed dramatically. Historically, state hospitals provided long-term care, using a custodial model. Today, with increased reliance on community-based programs, state hospitals are providing shorter term, more intensive, active treatment - with the goal of returning consumers to their home communities as soon as clinically appropriate. Similarly, the population currently served in training centers has changed, with the majority of current residents functioning at severe and profound levels of mental retardation. A large proportion of these individuals is non-ambulatory, requiring specialized wheelchairs, or needs significant staff assistance to walk. Many have multiple complex medical conditions such as seizures, scoliosis, gastro-intestinal problems, hearing or visual deficits or loss, and speech impairments and may often require specialized equipment and accommodations. These medical needs are projected to increase in the years to come as the training center population ages. In addition, training centers are experiencing greater demands to serve persons who have mild or moderate mental retardation but also have challenging behaviors that require significant behavioral interventions.

• A commensurate change in state facility physical plants has not occurred and many currently occupied buildings are not appropriate for the types of individuals who now need state facility services. Many of these buildings also are inefficient to operate. Where previously there was a need for a multi-building campus setting, opportunities now exist to provide services within a single building at a greatly reduced cost. State training centers, particularly, need to be redesigned to serve individuals with the most severe and profound disabilities and those with behavioral challenges that make it difficult to find community placements.

• The Department must bring existing state facility living areas up to current life safety standards. Consumers with more physical disabilities require accessible space and accommodation of adaptive equipment. However, some buildings lack the accessibility appropriate for the level of physical disabilities experienced by persons now receiving facility services. Other buildings lack current fire detection systems and other early detection safety systems. These buildings require major renovations to bring them into compliance with current codes and certification requirements.

Capital Investment Alignment

The Department's Capital Improvement Plan has two essential components: the first proposes projects necessary to keep operational buildings in use for the next two biennia, including roof, utility, HVAC, and food service repairs and environmental hazard abatement; the second is a phased program of facility replacements. Training centers that do not meet code requirements and are not appropriately configured to meet the needs of their current populations will be replaced with new facilities. Some that currently operate in numerous buildings over hundreds of acres will be replaced with fewer, more efficient and effective buildings at reduced operating costs. Sprawling state hospital campuses will be replaced with smaller, more effective and efficient single-building facilities.

Agency Strategic Plan

Department Of Mental Health, Mental Retardation and Substance Abuse Services

Agency Goals

Goal #1:

Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policy and practices that reflect the unique circumstances of individuals receiving MH, MR, or SA services.

Goal Summary and Alignment:

This goal envisions the alignment of services system policies, regulatory requirements, funding incentives, administrative practices, and services and supports arrangements with the core values of self-determination, empowerment, recovery, and resilience at the state and local levels. Opportunities for consumer and family involvement on Department policy and program committees would be increased. A statewide educational campaign and other training opportunities would help state and local government policy-makers and administrators, consumers, family members, and services and supports providers understand and have the necessary competencies and skills to employ consumer-driven, recovery, resilience, and person-centered practices. Other transformation activities would be initiated by the Department to implement recovery, resilience, and person-centered principles and practices in areas such as prevention and health promotion, consumer and family involvement and inclusion, access and engagement, continuity of care, individualized recovery and person-centered planning, recovery support and personal assistance, community inclusion, housing and work, evidence-based or best and promising practices, cultural competency, quality assurance, and performance monitoring.

Implementation of this goal is essential for transforming the Commonwealth's mental health, mental retardation, and substance abuse services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #1

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #2:

Expand and sustain services capacity necessary to provide services when and where they are needed, in appropriate amounts, and for appropriate durations.

Goal Summary and Alignment:

This goal envisions statewide availability of a core array of recovery and resilience-oriented and person-centered services and supports that are appropriate to the needs of individuals with mental illnesses, mental retardation, or substance use disorders who are in crisis or who have severe or complex conditions, or both, and cannot otherwise access needed services or supports because of their level of disability, their inability to care for themselves, or their need for a structured environment. Every locality would have the capacity to provide, either locally or through regional arrangement, crisis access and response services 24 hours per day and seven days a week. Existing unmet needs would be addressed through a core array of services and supports choices that is available to each individual regardless of where he or she lives in the Commonwealth. These recovery and resilience-oriented and person-centered services would be flexible and provided as close to the individual's home and natural supports as possible. Natural support systems including consumer and family networks, services, and supports, would be strengthened wherever possible and emphasis would be placed on prevention and early intervention to avoid future crises.

Implementation of this goal is essential for transforming the Commonwealth's mental health, mental retardation, and substance abuse services system to one that fully realizes the Department's vision for achieving a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #2

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #3:

Align administrative and funding incentives and organizational processes to support and sustain quality consumer-focused care, promote innovation, and assure efficiency and cost-effectiveness.

Goal Summary and Alignment:

This goal envisions adequate amounts of stable state and local funding that can be used flexibly to meet the needs of individual consumers and their families. Mental health, mental retardation, and substance abuse funding streams would be integrated to the extent possible to create individualized, recovery-oriented, and person-centered services plans. Opportunities for self-directed care would be pursued and full advantage would be taken of federal funding opportunities, including Medicaid, to implement recovery- and resilience-oriented and person-centered services. Funding allocations would include incentives for efficient and cost-effective services that are consistent with evidence-based or best and promising practices.

Implementation of this goal is essential for transforming the Commonwealth's mental health, mental retardation, and substance abuse services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #3

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #4:

Assure that services system infrastructure and technology efficiently and appropriately meet the needs of individuals receiving publicly funded MH, MR, and SA services and supports.

Goal Summary and Alignment:

This goal envisions significant improvement in the adequacy and appropriateness of state and community capital infrastructure. State facility and community buildings would be upgraded to ensure consumer safety and provide adequate and appropriate space designed to meet the needs of consumers. State training centers would be replaced with Intensive Support Centers (ISCs) and Intensive Support Homes (ISHs), as envisioned in the MR Services and Supports Options by Level of Care Model. Large state mental hospitals on multi-building campuses would be replaced with smaller, more efficient and appropriately designed facilities. The services system also would take advantage of technologies to improve care coordination and continuity. Technologies such as an electronic health record, teletherapy and teleconsultation would be implemented to improve coordination and continuity of service delivery, support the development of promising practices, and increase access to services in underserved areas.

Implementation of this goal is essential for transforming the Commonwealth's mental health, mental retardation, and substance abuse services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #4

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #5:

Obtain sufficient numbers of professional, direct care, administrative, and support staff with appropriate skills and expertise to deliver quality care.

Goal Summary and Alignment:

This goal envisions a MH, MR, and SA services system workforce with leadership, technical, and collaboration (team) skills and expertise. The services system would have the resources necessary to competitively recruit and retain sufficient numbers of professional and direct care staff. The services system workforce would have appropriate skills and expertise to deliver evidence-based or best and promising practices. Public-academic partnerships with Virginia universities, colleges, and community colleges would expand the pipeline for and skill levels of hard-to-fill professional and direct care positions. Cross-training programs would be designed to develop provider skills necessary to meet the needs of the most challenging consumers, including individuals with co-occurring disorders.

Implementation of this goal is essential for transforming the Commonwealth's mental health, mental retardation, and substance abuse services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #5

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #6:

Enhance service quality, appropriateness, effectiveness, and accountability through performance and outcomes measurement and service delivery and utilization review.

Goal Summary and Alignment:

This goal envisions statewide implementation of clinical and management practices that reflect best and promising practices and promote stewardship and wise use of system funds, human resources, and capital infrastructure. The services system would implement consistent management practices that focus on and support the delivery of recovery-oriented and person-centered services and supports. Performance and outcomes measurement systems would demonstrate quality, efficiency, and cost-effectiveness through clearly defined performance and consumer outcome expectations.

Implementation of this goal is essential for transforming the Commonwealth's mental health, mental retardation, and substance abuse services system to one that fully realizes the Department's vision of a consumer-driven system of services and supports.

Statewide Goals Supported by Goal #6

- Engage and inform citizens to ensure we serve their interests.
- Inspire and support Virginians toward healthy lives and strong and resilient families.